

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155771		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/06/2012	
NAME OF PROVIDER OR SUPPLIER FRANKLIN UNITED METHODIST COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W JEFFERSON ST FRANKLIN, IN 46131			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/21/2011.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00101366.</p> <p>This visit was also in conjunction with the PSR to the Investigation of Complaint IN00100421 completed on 12/7/2011.</p> <p>Survey dates: January 5 and 6, 2012</p> <p>Facility number: 001127 Provider number: 155771 AIM number: 200247220</p> <p>Survey team: Leia Alley, RN, TC Marcy Smith, RN Dinah Jones, RN</p> <p>Census bed type: SNF 20 NF 108 SNF/NF 10 NCC 26 Residential 155 Total 319</p> <p>Census payor type: Medicare 19 Medicaid 61 Other 239 Total 319</p> <p>Sample: 14</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	<p>Continued From page 1</p> <p>Franklin United Methodist Community was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey.</p> <p>Quality review completed 1/11/12 by Jennie Bartelt, RN.</p>			{F 000}			